Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1434 Howe Avenue, Suite 92
Sacramento, CA 95825-3236
(916) 263-2389 FAX (916) 263-2387
www.mbc.ca.gov

MEMBERS OF THE COUNCIL

Faith Gibson, L.M., Chair
Ruth Haskins, M.D., Vice Chair
Karen Ehrlich, L.M.
Carrie Sparrevohn, L.M.
Guillermo Valenzuela, M.D.
Barbara Yaroslavsky

MIDWIFERY ADVISORY COUNCIL

June 12, 2007

Medical Board of California
Greg Gorges Conference Room
1424 Howe Avenue
Sacramento, CA 95825
(916) 263-2382

Action may be taken on any item listed on the agenda.

AGENDA

1:00 p.m.

Members of the Board who are not members of the Council may be attending the meeting as observers.

1. Call to Order/Roll Call
2. Approval of Minutes of the March 9, 2007 and April 17, 2007 Meetings – Ms. Gibson
3. Role, Responsibility, Mission and Vision of Council – Ms. Gibson
4. Midwife Annual Report Coding System (Business and Professions Code § 2516)
5. Midwifery Assessment and Clinical Evaluation Discussion
6. Public Comment on Items not on the Agenda
7. Adjournment

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.
NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Billie Baldo at (916) 263-2365 or sending a written request to Ms. Baldo at the Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number.
Meetings of the Midwifery Advisory Council are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Council, but the Chair may apportion available time among those who wish to speak.   **********   ***For additional information, contact the Licensing Program at (916) 263-2382.***

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

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Midwifery Advisory Council

Greg Gorges Conference Room
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Sacramento, CA 95825

March 9, 2007

DRAFT MINUTES DRAFT

Agenda Item 1 - Call to Order/Roll Call

The Midwifery Advisory Council of the Medical Board of California - Division of Licensing's inaugural meeting was called to order by Gary Qualset, Chief, Division of Licensing (DOL), at 10:10 a.m. A quorum was present and due notice had been mailed to all interested parties.

Members Present:
- Karen Ehrlich, LM
- Faith Gibson, LM, Chair
- Ruth Haskins, MD, Vice Chair
- Carrie Sparrevohn, LM
- Guillermo J. Valenzuela, MD
- Barbara Yaroslavsky

Staff Present:
- Billie Baldo, MST, Administrative Assistant, Licensing Program
- Kathi Burns, Staff Services Manager I, Licensing Program
- Diane Ingram, Manager, Information Systems Branch
- Scott Johnson, Business Services Assistant, Business Services Office
- Kimberly Kirchmeyer, Deputy Director
- Mike McCormick, Associate Governmental Program Analyst
- Kelly Nelson, Legislative Analyst
- Gary Qualset, Chief, Licensing Program
- Anita Scuri, Legal Counsel, Department of Consumer Affairs
- Pam Thomas, Analyst, Licensing Program
- Linda Whitney, Chief, Legislative/Regulatory Unit

Members of the Audience:
- Bruce Ackerman, Midwives Alliance of North American (MANA)
- Claudia Breglia, California Association of Midwives (CAM)
- Genie DeKruyf, LM

Candace Diamond, Manager, Patient Data Section, Office of Statewide Health Planning and Development (OSHPD)
Lucinda Johnston-Chiszar, Californians Advocating Licensed Midwifery (CALM)
Tosi Marceline, LM
Robyn Strong, Analyst, OSHPD
Sunshine Tomlin, LM

Agenda Item 2 - Bagley-Keene Open Meeting Act

Anita Scuri, Legal Counsel, made a presentation to MAC members regarding the Bagley-Keene Open Meeting Act. Ms. Scuri defined what constituted a public meeting and provided examples of legal meetings and different types of member interactions that could result in violations.

Various questions from MAC members were fielded by Ms. Scuri and she provided clarifications and several examples were discussed during the presentation.

Agenda Item 3 - Election of Officers

Ms. Sparrevohn requested discussion and clarification of the expectations and duties required of the Midwifery Advisory Council Chair and Vice Chair.

Ms. Scuri explained the Chair would control the flow of meetings and agenda items. Staff would be allowed to discuss various issues and items in between meetings with the Chair and/or Vice Chair. The Vice Chair would fill in during an absence of the Chair.

Ms. Sparrevohn nominated Dr. Haskins for Chair.

Dr. Haskins stated she would prefer a licensed midwife be the Chair and nominated Faith Gibson to the position. Dr. Haskins stated she would accept a Vice Chair nomination.

Appointments by acclamation were made as follows: Chair - Faith Gibson, LM; Vice Chair - Ruth Haskins, MD.

Agenda Item 4 - Role, Responsibility, Mission and Vision of Council

Roberts Rules of Order were mentioned as an item for discussion and adoption. Ms. Scuri informed MAC members that Roberts Rules of Order could be followed to the extent it does not conflict with the Bagley-Keene Open Meeting Act.

Mr. Qualset referenced the draft document in the agenda packet as a starting point to assist the MAC in developing its Roles, Responsibilities, Mission and Vision statements.

Discussion ensued regarding each topic area. The members developed draft language to be brought back before the MAC at its next meeting for review and final approval.

Mission - To protect the healthcare consumer by assisting the Division of Licensing in developing appropriate standards for licensing, standards of care, and regulation for the practice of midwifery.

Role - The Midwifery Advisory Council shall meet in public not less than four times a year to discuss topics of importance related to the practice of midwifery in order to make recommendations to and advise the Division of Licensing.

Responsibility - The Midwifery Advisory Council shall provide ongoing sound and reliable expert advice to the Division of Licensing to facilitate the safe and sound practice of midwifery including the development and ongoing maintenance of a coding system for gathering annual practice data of midwives in California.

Vision - In promoting the Medical Board of California's consumer protection interests, the Midwifery Advisory Council will provide ongoing sound and reliable expert advice in serving as a vehicle for further positive discussion on the practice of midwifery and home births in the State of California.

Agenda Item 5 - Midwife Annual Report Coding System (Business & Professions Code Section 2516)

Ms. Sparrevohn suggested working from pages 9-15 of the agenda packet and to incorporate terms from the Standards of Care document into the coding system.

Ms. Yaroslavsky suggested the Chair appoint a task force of up to two members of the MAC and other interested parties from the relevant community.

Ms. Scuri stated a limit of two for the task force can be allowed without notice to the public.

Dr. Haskins recommended a physician and surgeon be included on the task force and volunteered to serve. Ms. Sparrevohn also volunteered for the task force.

Interested parties were advised to let Ms. Gibson know if they wish to serve on the task force.

Mr. Qualset stated various sources were used to create the draft document for use as a starting point.

Candace Diamond, Manager, Patient Data Section of OSHPD, expressed eagerness to participate on the task force.

Ms. Sparrevohn solicited additional coding ideas from interested parties and noted the MAC will also need to decide on how to report outcomes for licensed midwives who work in group practices.

Agenda Item 6 - Schedule of Future Meetings

Ms. Erlich suggested more time be allotted for future MAC meetings.

Mr. Qualset listed potential MAC dates to be considered. He indicated a 10-day public notice was required and staff needs approximately 3-4 weeks in order to prepare for the meeting.

It was M/S/C (Erlich/Haskins) to establish MAC meeting dates on May 24, 2007, August 30, 2007, and December 6, 2007.

Agenda Item 7 - Public Comment on Items not on the Agenda

Genie DeKruyf, LM, stated she has worked in a nonprofit community health clinic in Orange County and attends home births. The clinic was recently audited by the Department of Health Services - Medi-Cal Division. As a result of the audit, Ms. DeKruyf was placed on unpaid administrative leave. Ms. DeKruyf requested that a letter from the MBC be prepared to clarify the issues raised in the audit report. Ms. DeKruyf urged the involved departments to communicate in order to resolve the issue quickly so she could return to work.

Ms. Sparrevohn stated it could be a potential agenda item for MAC to develop standards for hospital and clinic settings to delineate differences between each practice setting, as current standards of care pertain primarily to out-of-hospital birth settings. Additionally, Ms. Sparrevohn thought another MAC agenda item could be discussing the issue of asking Medi-Cal to consider licensed midwives as approved providers.

Dr. Valenzuela stated various changes in healthcare, including issues of Medi-Cal fraud, had placed many Medi-Cal providers in similar situations. He did not intend to minimize Ms. DeKruyf's predicament but noted it is not a unique occurrence as audits are becoming widespread.

Ms. Scuri requested a copy of the report to be provided to the staff of the DOL as it was not on the agenda and; therefore, could not be addressed during today's public comments.

Ms. Yaroslavsky recommended the issue needed to be dealt with by staff in a structured and procedural process prior to being presented to the MAC.

Tosi Marceline, LM, inquired as to the authority of the MAC in relation to the DOL, and expressed her displeasure with the term "lay-midwives" that is still on the Board's website and a title still used today in practice settings.

Agenda Item 8 - Adjournment

Meeting adjourned at 12:10 p.m.

State of California, Department of Consumer Affairs

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

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Midwifery Advisory Council

Greg Gorges Conference Room
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Sacramento, CA 95825

April 17, 2007

DRAFT MINUTES DRAFT

Agenda Item 1 - Call to Order/Roll Call

The Midwifery Advisory Council of the Medical Board of California - Division of Licensing was called to order by Chair Faith Gibson at 11:08 a.m. A quorum was present and due notice had been mailed to all interested parties.

Members Present:

Faith Gibson, LM, Chair
Ruth Haskins, MD, Vice Chair
Karen Ehrlich, LM
Carrie Sparrevohn, LM

Staff Present:

Billie Baldo, MST, Administrative Assistant, Licensing Program
Stacie Berumen, Staff Services Manager I, Licensing Program
Kathi Burns, Staff Services Manager I, Licensing Program
Diane Ingram, Manager, Information Systems Branch
Scott Johnson, Business Services Assistant, Business Services Office
Mike McCormick, Associate Governmental Program Analyst, Licensing Program
Camille McGee, Associate Governmental Program Analyst, Diversion Program
Gary Qualset, Chief, Licensing Program
Pam Thomas, Analyst, Licensing Program

Members of the Audience:

Bruce Ackerman, Midwives Alliance of North American (MANA)
Claudia Breglia, California Association of Midwives (CAM)
Edana Hall, LM
Diane Holzer, MANA/CAM
Lucinda Johnston-Chiszar, Californians Advocating Licensed Midwifery (CALM)
Chinwe Lucy Marchie, LM, Nigeria
Alison E. Price, LM
Robin Strong, Analyst, Office of Statewide Health Planning and Development (OSHPD)

Agenda Item 2 - Midwife Annual Report Coding System (Business and Professions Code Section 2516)

Medical Board employees of the Division of Licensing and Ms. Robyn Strong, OSHPD representative, were introduced by Gary Qualset, Chief of Licensing. Mr. Qualset stated this MAC meeting would proceed in the style of a workshop and include input from all interested parties. The group would focus on developing a coding system as required in Business & Professions (B&P) Code section 2516 to gather data from licensed midwives regarding their services when the intended place of birth at the onset of care is an out-of-hospital setting. Attachments were referenced in the agenda packet for the public and task force to work from.

The following comments were made as discussion ensued prior to work beginning on modifying the draft reporting document.

Lucinda Johnston-Chiszar, CALM, commented on the amount of work it would take for midwives to gather and transfer data as specified by law.

Claudia Breglia, CAM, expressed interest in working with the draft form created by Ms. Gibson. Ms. Gibson stated the form was developed from four different sources and condensed into the provided document.

Bruce Ackerman, Research Division, MANA, stated 60 California midwives are currently involved with web-based data collection and registration. He indicated that MANA currently has a report form for midwives; however, a form revision was forthcoming with a specific focus on California's needs. He inquired about the potential for multiple outcomes for a midwife/patient and how it might best be captured or reported as a data element.

Diane Holzer, President of MANA and CAM member, indicated she preferred to work with the CAM form as opposed to the draft form created by Ms.Gibson.

Mr. Qualset expressed concern about including definitions on the form and clarified the Board will create the form itself in consultation with MAC and OSHPD and that today the group should focus on identifying the necessary codes for data collection.

Ms. Strong stated free text should not be included or encouraged as it can hinder the collection of reliable data.

Both Ms. Strong and Mr. Ackerman indicated 3rd party data providers may be available to assist midwives in reporting data using OSHPD's required format, when that time comes.

Dr. Haskins inquired about the time frames mandated by B&P Code section 2516. Ms. Strong explained that the names of midwives who reported data would be provided to the Board by March 31, 2008, with aggregate data subsequently supplied by June 30, 2008. The Board is required to finalize

and incorporate the aggregate data into the Board's Annual Report to the Legislature later in calendar year 2008. Mr. Qualset noted the law requires collection of this data by midwives for the 2007 calendar year.

International Classification of Diseases codes, 9th revision (ICD 9) were mentioned as a possible reference. Ms. Sparrevohn stated ICD 9 codes would be overly burdensome for midwives as midwives do not regularly bill or work with these codes. Dr. Haskins echoed this sentiment and felt it would be better to create a reasonable list for the first couple of years and then modify if necessary; instead of overwhelming midwives with a cumbersome reporting process. Ms. Erlich raised the possibility of soliciting feedback from midwives for future revisions.

Discussion ensued over the multiple categories, listings, and issues to be resolved and captured into the master draft document. Various items were debated, moved, amended, and deleted on the form when deemed necessary by the workgroup to effectively and accurately capture data as required by statute.

It was M/S/C (Erlich/Sparrevohn) to ask the Division of Licensing to do whatever necessary to incorporate the final compilation of codes and categories into a form for collecting midwife data.

The draft with amendments from this meeting will be brought back for final review, comment, and completion at the June 12, 2007, MAC meeting.

Agenda Item 3 - Schedule of Future Meetings

The MAC discussed its upcoming schedule of meetings and opted to reschedule the May 24, 2007 meeting to June 12, 2007.

It was M/S/C (Sparrevohn/Gibson) to hold the next MAC meeting on Tuesday, June 12, 2007, at 1:00 p.m.

Agenda Item 4 - Public Comment on Items not on the Agenda

Ms. Erlich requested to include into the public comment record an e-mail she had received from Genie DeKruyf, LM. A copy is attached to these minutes as Attachment A.

Ms. Erlich asked if the Board was consulting with the MAC as the prescription issue may affect all licensed midwives in similar work environments. She was aware of another licensed midwife working in Northern California under similar circumstances. Ms. Erlich felt Ms. DeKruyf's letter needed to be discussed in the general proceedings of MAC and would like the issue on the MAC agenda at some point in time. Further, she stated she didn't know what might be required to address this issue but wondered if legislation or discussion with the Board's Midwifery Committee and the Division of Licensing might be a possible start.

Dr. Haskins expressed her concern and cautioned the MAC members about bringing up a potential scope of practice topic during this calendar year as the timing may not be right.

CAM representatives thanked the MAC for their hard work on this project.

Agenda Item 5 - Adjournment

The MAC meeting was adjourned at 2:30 p.m.

State of California

Department of Consumer Affairs
Medical Board of California

M e m o r a n d u m

To : **Midwifery Advisory Council Members** **Date:** May 29, 2007

From : Mike McCormick-Program Analyst
Licensing Operations

Subject : Role, Responsibility, Mission, and Vision Statements

The attached document contains the **Role**, **Responsibility**, **Mission**, and **Vision** statements for the MAC as developed at its April 17, 2007 meeting. As requested, these statements are being brought before the MAC for final review.

Midwifery Advisory Council

ROLE

The Midwifery Advisory Council shall meet in public not less than four times a year to discuss topics of importance related to the practice of midwifery in order to make recommendations to and advise the Division of Licensing.

RESPONSIBILITY

The Midwifery Advisory Council shall provide ongoing sound and reliable expert advice to the Division of Licensing to facilitate the safe and sound practice of midwifery including the development and ongoing maintenance of a coding system for gathering annual practice data of midwives in California.

MISSION

To protect the healthcare consumer by assisting the Division of Licensing in developing appropriate standards for licensing, standards of care, and regulation for the practice of midwifery.

VISION

In promoting the Medical Board of California's consumer protection interests, the Midwifery Advisory Council will provide ongoing sound and reliable expert advice in serving as a vehicle for further positive discussion on the practice of midwifery and home births in the State of California.

Agenda Item #4

Midwifery Advisory Council Meeting April 17, 2007

Work product for categories of 'Reasons & Complications'
for transfer and codified designations

Elective Antepartum transfer of care to a health care practitioner

Antepartum transfer, **Elective / maternal** conditions (AE-m)

AE-m 1 Medical or mental health conditions *unrelated* to pregnancy
AE-m 2 Hypertension developed in pregnancy
AE-m 3 Blood coagulation disorders, incl. phlebitis
AE-m 4 Anemia, persistent vomiting with dehydration,
AE-m5 Nutritional & weight loss issues, failure to gain weight
AE-m 6 Gestational diabetes, unable to control with diet
AE-m 7 Vaginal bleeding, suspected placental implantation abnormalities
AE-m 8 Miscarriage
AE-m 9 Termination of pregnancy
AE-m 10 HIV test positive
AE-m 11 Preterm labor or preterm rupture of membranes
AE-m 12 Client request

Antepartum transfer, **Elective / feta**l conditions (AE-f)

AE-f 1 Intrauterine growth restriction, fetal anomalies
AE-f 2 Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios
AE-f 3 Intrauterine growth restriction, (IUGR), fetal anomalies
AE-f 4 Fetal heart irregularities
AE-f 5 Non vertex lie at term, multiple gestation
AE-f 6 Other

Antepartum Urgent or **Emergent** / **maternal** conditions

AU-m 1 Non pregnancy related medical condition
AU-m 2 Severe or persistent headache, pregnancy-induced hypertension (PIH) or preeclampsia
AU-m 3 Isoimmunization, severe anemia, or other blood related issues
AU-m 4 Significant infection
AU-m 5 Significant vaginal bleeding
AU-m 6 Preterm labor or preterm rupture of membranes

AU-f 1 Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test (NST)
AU-f 2 Fetal demise

AU-f 3 Other

Intrapartum transfers of care (active labor true delivery of placenta)

Intrapartum transfer, **Elective** / **maternal** conditions (IE-m)

IE-m1 Client request; request for pain relief
IE-m2 Persistent increase in blood pressure
IE-m3 Active herpes lesion
IE-m4 Abnormal bleeding
IE-m5 Signs of infection
IE-m6 Prolonged rupture of membranes
IE-m7 Lack of progress; maternal exhaustion; dehydration

Intrapartum transfer, **Elective / fetal** conditions (IE-f)

IE-f 8 Fetal heart tones irregularities; thick me conium
IE-f 9 Non-vertex presentation; unstable lie
IE-f 10 Other

==========

Intrapartum transfer, **Urgent or Emergent / maternal** conditions (IU-m)

IU-m 1 Preeclampsia, eclampsia, seizures
IU-m 2 Significant vaginal bleeding including suspected placental abruption with severe abdominal pain inconsistent with normal labor.
IU-m 3 Uterine rupture
IU-m 4 Maternal shock, loss of consciousness

Intrapartum transfer, **Urgent or Emergent / fetal** conditions (IU-f)

IU-f 1 Prolapsed umbilical cord
IU-f 2 Fetal distress
IU-f 3 Other life threatening conditions or symptoms

Postpartum transfer of care (first 6 wks)

Postpartum transfer, **Elective** conditions

PE- 1 Client request
PE- 2 Adherent or retained placenta
PE- 3 Repair of laceration beyond level of midwife's expertise
PE- 4 Signs of significant infection
PE- 5 Postpartum depression
PE- 6 Social, emotional or physical conditions outside of scope of practice
PE- 7 Excessive or prolonged much bleeding in later postpartum period

Postpartum transfer, **Urgent** or emergency

PU- 1 Abnormal or unstable vital signs
PU- 2 Uterine inversion, rupture or prolapse
PU- 3 Uncontrolled hemorrhage
PU- 4 Seizures or unconsciousness, shock
PU- 5 Infection
PU- 6 Postpartum psychosis

Neonatal Transfers of Care

Neonatal, Elective

NE-1 Parental request
NE-2 Low birth weight
NE-3 Congenital anomalies, birth injury
NE-4 Poor transition to extrauterine life
NE-5 Insufficient passage of urine or meconium;
NE-6 Pernicious vomiting
NE-7 Other medical conditions

Neonatal, Urgent or **Emergent**

NU-1 Abnormal vital signs or color, poor tone, lethargy, no interest in nursing
NU-2 Signs or symptoms of infection
NU-3 Abnormal cry, seizures or loss of consciousness
NU-4 Significant jaundice at birth or within 30 hours
NU-5 Evidence of clinically significant prematurity
NU-6 Congenital anomalies, birth injury, other medical conditions

NU-7 Significant dehydration,
NU-8 Abnormal bulging or depression of fontanel

Complications leading to maternal-infant mortality

Mother

C-m 1 Blood loss
C-m 2 Sepsis
C-m 3 Eclampsia/toxemia or HELLP syndrome
C-m 4 Embolism (pulmonary or amniotic fluid)

Baby

C-b1 Infection
C-b2 Anomaly incompatible with life
C-b3 Meconium aspiration, other respiratory issues
C-b4 Neurological issues/seizures
C-b5 Other medical issue
C-b6 Unknown

Birth Outcomes

Maternal
O-m1 Vaginal birth with no complications
O-m2 Cesarean delivery with no complications
O-m3 Serious pregnancy/birth related medical complications persisting beyond 6 weeks
O-m4 Maternal death

Fetal/Neonatal
O-f/n 1 Fetal demise diagnosed prior to labor
O-f/n 2 Fetal demise diagnosed during labor or at delivery
O-f/n 3 Birth related medical complications or birth injury persisting beyond 6 weeks
O-f/n 4 Infant death
==========

Pursuant to Section 2516 of the Business and Professions Code all licensed midwives (LM) are required to submit statistics for each client they served as primary caregiver, beginning with the calendar year 2007. If you are in a group practice where all midwives share primary responsibility for all clients and every primary midwife in your practice is an LM, you can submit this form as a practice. Midwives working in practices where each midwife has primary responsibility for a list of clients within the practice should fill out an individual form for the clients they serve as primary midwife. Any midwife attending additional births outside of the practice (where those births are not submitted with group practice statistics) must also submit an individual form listing those births.

For the purposes of this form ONLY the following definitions will be used:

- Primary caregiver=midwife or practice contracted by client to provide primary-care midwifery services during her pregnancy and/or out-of-hospital delivery.
- Collaborative care=midwife receives advice or client receives additional medical care or advice regarding the pregnancy from a licensed physician or surgeon.
- Under supervision =supervised by a licensed physician or surgeon who will go on record as being your supervisor for a particular case.
- Non-medical reason=client preference, relocation, insurance coverage issues, other inability to pay, lost to care.
- Intrapartum=midwife has begun to monitor/attend woman in labor, regardless of cervical dilatation or contraction pattern.
- Postpartum=baby has been born

Reporting as an:

Individual ☐

Group ☐

Individual Midwife Name and license number

OR

For Group practices:

List Each Midwife's Name and corresponding license number

Calendar Year Reporting

Please report the following information with regard to cases in which, you, the midwife or the group practice, assisted in the reporting year when the intended place of birth at the onset of care was an out-of-hospital setting AND also report the following information with regard to cases in which, any student midwife, you or the group practice supervised, assisted in the reporting year when the intended place of birth at the onset of care was an out-of-hospital setting.

1.A. Total number of clients served as primary caregiver whose intended place of birth at the onset of care was an out-of-hospital setting. If there were none, enter zero (0) and stop here and submit the form. [satisfies Section 2516 (a) (3) (A)]

1.B. of this number, total number of clients who left care for non-medical reasons. (Do not include these clients in other categories on this reporting form). If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (F)]

1.A. minus 1.B. equals 1.C. or the total number of clients who must be accounted for on the remainder of this form

1.C.

2. Of the number in 1.C., total number of clients served under supervision If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (C)]

3. Of the number in 1.C., total number of clients served with collaborative care. If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (B)]

4. Of the number in 1.C.the number of live births attended as the primary caregiver. (by county). If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (D)]

County	Number

5. Of the number in 1.C., total number of cases of fetal demise attended as primary caregiver, at the discovery of the demise. (by county). If there were none, enter zero (0).
[satisfies Section 2516 (a) (3) (E)]

County	Number

6. Of the number in 1.C., the total number of planned out of hospital births at the onset of labor. If there were none, enter zero (0).
[satisfies Section 2516 (a) (3) (J)]

7. Of the number in 1.C., the total number of planned out of hospital births completed in an out of hospital setting. If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (J)]

7.A. Of the total in number 7, how many were twins. If there were none, enter zero (0).
[satisfies Section 2516 (a) (3) (K-i)]

7.B. Of the total in number 7, how many were higher order multiples. If there were none, enter zero (0).
[satisfies Section 2516 (a) (3) (K-ii)]

7.C. Of the total in number 7, how many were breech at delivery. If there were none, enter zero (0).
[satisfies Section 2516 (a) (3) (K-iii)]

7.D. Of the total in number 7, how many were vaginal births after previous caesarian delivery, (VBAC). If there were none, enter zero (0).
[satisfies Section 2516 (a) (3) (K-iv)]

8. Of the number in 1.C., the number of non-emergency transfers of primary care during the antepartum period. **(Mother/Fetus counted as a unit).** If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (F)]

Reason	Number

9. Of the number in 1.C., the number of urgent or emergency transfers of primary care during the antepartum period **(Mother/Fetus counted as a unit).** If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (H)]

Reason	Outcome	Number

10. Of the number in 1.C., the number of non-emergency transfers of primary care during the intrapartum period. **(Mother/Fetus counted as a unit).** If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (G)]

Reason	Outcome	Number

11. Of the number in 1.C., the number of urgent or emergency transfers of primary care during the intrapartum period. **(Mother/Fetus counted as a unit).** If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (I)]

Reason	Outcome	Number

12. Of the number in 1.C., the number of non-emergency transfers of primary care during the postpartum period, of the mother. If there were none, enter zero (0).
[satisfies Section 2516 (a) (3) (G)]

Reason	Outcome	Number

13. Of the number in 1.C., the number of urgent or emergency transfers of primary care during the postpartum period, of the mother. If there were none, enter zero (0).
[satisfies Section 2516 (a) (3) (G)]

Reason	Outcome	Number

14. Of the number in 1.C., the number of non-emergency transfers of primary care during the postpartum period, of the baby. If there were none, enter zero (0)
[satisfies Section 2516 (a) (3) (I)]

Reason	Outcome	Number

15. Of the number in 1.C., the number of urgent or emergency transfers of primary care during the postpartum period, of the baby. If there were none, enter zero (0).
[satisfies Section 2516 (a) (3) (I)]

Reason	Outcome	Number

16. Of the number in 1.C., complications resulting in the mortality of mother. If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (L)]

Complication	Number

17. Of the number in 1.C., complications resulting in the mortality of baby/fetus. If there were none, enter zero (0). [satisfies Section 2516 (a) (3) (L)]

Complication	Number

Agenda Item #4

Reasons and Outcomes Codes for submitting Licensed Midwife Statistics pursuant to Section 2516 of the Business and Professions Code

REASONS

Antepartum transfers of care,
(Mother/Fetus counted as a unit)

Non-emergent

RA-1 Medical or mental health conditions not related to/caused by this pregnancy
RA-2 Vaginal bleeding
RA-3 Persistent vomiting with dehydration, nutritional and weight loss issues, failure to gain weight.
RA-4 Gestational diabetes
RA-5 Placenta anomalies or placental implantation abnormalities
RA-6 Abnormal amniotic fluid volume (oligo or polyhydramnios.
RA-7 Intrauterine growth restriction, fetal anomalies
RA-8 Positive HIV test
RA-9 Non vertex lie at term, Multiple gestation
RA-10 Loss of non-viable pregnancy (includes spontaneous and elective abortion)
RA-11 Blood Coagulation disorders, including phlebitis
RA-12 Fetal heart irregularities
RA-13 Client request
RA-14 Other (may include uncommon medical conditions affecting pregnancy)

Antepartum transfers of care,
(Mother/Fetus counted as a unit)

Urgent or Emergency

RA-15 Preterm labor or preterm rupture of membranes
RA-16 Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test.
RA-17 Severe or persistent headache, pregnancy induced hypertension, or pre-eclampsia

RA-18 Significant infection

Antepartum transfers of care,
(Mother/Fetus counted as a unit)

Urgent or Emergency (continued)

RA-19 Isoimmunization, severe anemia, or other blood related issues
RA-20 Non pregnancy related medical condition
RA-21 Significant vaginal bleeding
RA- 22 Fetal Demise
RA-23 Other

Intrapartum transfer of care
(Mother/Fetus counted as a unit)

Non-emergent

RI-1 Client request, request for medical methods of pain relief
RI-2 Prolonged rupture of membranes
RI-3 Lack of progress/maternal exhaustion/dehydration
RI-4 Abnormal bleeding
RI-5 Active herpes lesion
RI-6 Signs of infection
RI-7 Thick meconium in the absence of evidence of fetal distress.
RI-8 Non-vertex presentation/unstable lie
RI-9 Persistent hypertension, Severe or persistent headache,
RI-10 Other

Intrapartum transfer of care
(Mother/Fetus counted as a unit)

Urgent or emergency

RI-11 Prolapsed umbilical cord
RI-12 Significant vaginal bleeding including suspected placental abruption with severe abdominal pain inconsistent with normal labor.
RI-13 Pregnancy induced hypertension, pre-eclampsia, eclampsia, seizures
RI-14 Uterine rupture
RI-15 Maternal shock, loss of consciousness
RI-16 Fetal distress
RI-17 Other life threatening conditions or symptoms

Immediate Postpartum Transfer of Care
Mother

Non-emergent

RPM-1 Client request
RPM-2 Adherent or retained placenta without significant bleeding
RPM-3 Repair of laceration beyond level of midwife's expertise
RPM-4 Signs of infection
RPM-5 Postpartum depression
RPM-6 Social, emotional or physical conditions outside of scope of practice.
RPM-7 Excessive or prolonged bleeding in later postpartum period

Immediate Postpartum Transfer of Care
Mother

Urgent or emergency

RPM-8 Adherent or retained placenta with significant bleeding
RPM-9 Abnormal or unstable vital signs
RPM-10 Uterine inversion, prolapse or rupture
RPM-11 Uncontrolled hemorrhage
RPM-12 Seizures or unconsciousness, shock
RPM-13 Post partum psychosis
RPM-14 Other life threatening conditions or symptoms

Immediate Postpartum Transfer of Care
Infant

Non-emergent

RPI-1 Parental request
RPI-2 Poor transition to extra-uterine life
RPI-3 Low birth weight
RPI-4 Congenital anomalies, birth injury, other medical conditions
RPI-5 Insufficient urine or meconium
RPI-6 Other

Immediate Postpartum Transfer of Care
Infant

Urgent or emergency

RPI-7 Significant cardiac or respiratory issues, low 5-minute Apgar
RPI-8 Abnormal vital signs or color, lethargy, poor tone, no interest in nursing
RPI-9 Signs or symptoms of infection
RPI-10 Abnormal cry, seizures or loss of consciousness, abnormal bulging of fontanels
RPI-11 Significant jaundice at birth or within 30 hours of birth
RPI-12 Evidence of prematurity
RPI-13 Congenital anomalies, birth injury, other medical conditions of an emergent nature

Immediate Postpartum Transfer of Care
Infant

Urgent or emergency (continued)

RPI-14 Significant dehydration or depression of fontanels
RPI-15 Other

Complications leading to mortality

Maternal

C-1 Blood loss
C-2 Sepsis
C-3 Eclampsia/toxemia or HELLP syndrome
C-4 Embolism (pulmonary or amniotic)
C-5 Other

Fetal/Infant

C-6 Infection
C-7 Anomaly incompatible with life
C-8 Meconium aspiration or other respiratory issues
C-9 Neurological issues/seizures
C-10 Other
C-11 Unknown

Outcomes

Maternal

O-1 Vaginal Birth with no complications
O-2 Cesarean delivery with no complications
O-3 Serious pregnancy/birth related medical complications persisting beyond 6 weeks
O-4 Maternal Death

Fetal/Infant

O-5 Healthy live infant
O-6 Fetal demise diagnosed prior to labor
O-7 Fetal demise diagnosed during labor or at delivery
O-8 Birth related medical complications or birth injury persisting beyond 6 weeks
O-9 Neonatal death